Unit Updates

Missouri Department of Health and Senior Services
Unit of Home Care and Rehabilitative Standards

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THIS INFORMATION SHOULD BE DIRECTED TO THE MANAGEMENT STAFF OF YOUR AGENCY

Note from Lisa Coots, RN, Administrator

Effective February 23, 2004, I assumed the position of Administrator for the Unit of Home Care and Rehabilitative Standards. For 2 years prior, I had served as the Assistant Administrator, assisting Linda Grotewiel with the overall functioning of the Unit.

Looking back, it is amazing the amount of knowledge and information obtained while serving as Assistant Administrator. However, questions and unique scenarios arise daily. Be assured I will respond to your needs in a timely fashion. You the providers of home health, hospice, OPT and CORF are a great group and do such important work with the citizens of Missouri. I appreciate the quality of care you provide and look forward to serving you in my new role.

If you have any questions or concerns, please don't hesitate to give me a call at 573/751-6336.

OASIS Education Coordinator back under Home Care and Rehabilitative Standards

Due to reorganization within the Department, the position of OASIS Education Coordinator was moved back under the Unit of Home Care and Rehabilitative Standards. Effective March 22, Beverly Rex, one of the surveyors in the Central location accepted this position. In addition to her role and duties as OASIS Coordinator, she will be assisting the administrator.

Beverly is very excited about her new position. She looks forward to working with you, assisting with all your OASIS needs. She can be reached at 573/751-6336 or email at rexb@dhss.mo.gov.

Changes within the Section for Health Standards and Licensure

Effective April 12, 2004, Lois Kollmeyer accepted a position in the Office of the Director. Her new title is Quality Review Specialist. Some of her new duties will include issues relating to the Patient Safety Commission and the Pain Commission. Cindy Schmutzler will be serving as Interim Section Director for Health Standards and Licensure. See the attached organizational chart for the Section for Health Standards and Licensure.

Pending Agencies

As of mid April, the Unit had 26 pending agencies:

- 11 Home Health
- 7 Hospice
- 8 OPT

Home Health Aide Competency Exam

In reviewing the more recent home health aide competency evaluation packet of information, it was determined nowhere in the instructions does it say the home health aide has to have answered 3 out of 5 questions correctly on each section to pass. Somehow in the reprinting this was omitted.

It is however noted on the answer sheets under each section "no less than 3 correct". The surveyor when reviewing the home health aide personnel file does need to see each section of the test scored.

Reminder regarding duties assigned to the home health aide

Any assignment other than personal care made to a home health aide should be indicated on the 485 (plan of care) and signed by the physician. Assignments such as blood pressure, simple dressing changes, applying ted hose, etc., task that require extra training all of these need to be included. Also, remember that there needs to be documentation in the aide personnel file he/she was trained and checked off on these additional tasks.

What are aides allowed to do?

The Missouri State Board of Nursing has the legal responsibility to monitor any and all nursing activities. The Board recognizes that activities of unlicensed assistive personnel need to be monitored to protect the health, safety and welfare of the public. When the registered nurse delegates selected nursing tasks, the responsibility and accountability to the public for the overall nursing care remains with the registered nurse. The burden of determining the competency of the person who will perform the tasks and of evaluating the situations rests with the registered nurse. Delegated activities should be limited to highly prescribed repetitive tasks that do not call for judgments. When unlicensed persons perform nursing functions without benefit of instruction or supervision by nurses, this constitutes the practice of nursing without a license.

Advance Beneficiary Notice

For services ordered after January 1, 2004, the home health agency does not have a choice of forms to use. The only form to be used as an Advanced Beneficiary Notice is the CMS-R-296 form. This is to inform patients the agency is refusing or reducing physician-ordered care. These new forms can be obtained online: http://cms.hhs.gov/medicare/bni/CMSR296_JUNE2002.pdf

Physician Rubber Stamp Signatures

Even though the Medicare Program Integrity Manual, Transmittal 59 is now allowing rubber stamped signatures, CMS, the unit of survey and certification, has not changed their policy of not allowing stamped signatures. Mavis Connolly with CMS stated they were meeting regarding this issue; however, the policy has not been changed.

If and when our unit is notified of a policy change, the information will be disseminated on our website at http://www.dhss.state.mo.us/Home_Health. Please continue to check this site weekly for any updates.

Clarification regarding Group of Professional Personnel at Tag G152

The regulations for the group of professional personnel are found at 42 CFR 484.16 and include language describing the group as "appropriate representation from other professional disciplines". Since this group is to advise on professional issues and the agency scope of services, CMS clarified that the disciplines would be in the health care field (similar to the services the agency offers). Bankers, teachers, attorneys, etc. wouldn't be considered appropriate for this group.

Clarification regarding Hospice Volunteer Hours

The regulation at 42 CFR 418.70(e) requires the hospice to document and maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum equals 5% of the total patient care hours of all paid hospice employees and contract staff.

CMS clarified that agencies **cannot** count the hours they spend in the general orientation and training about the hospice philosophy, employee issues, education, support, marketing or time in attendance of board meetings toward that 5%.

Impact of Section 946 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) on the Hospice Core Services Requirement:

Effective December 8, 2003, Section 1861(dd)(5) of the Social Security Act has been modified to permit a hospice program to enter into arrangements with another hospice program for the provision of nursing services, medical social services, and counseling in extraordinary, exigent, or other non-routine circumstances. Examples of such extraordinary circumstances might include unanticipated periods of high patient loads, staffing shortages due to illness, or other **short term temporary events or temporary travel** of a patient outside the hospice's service area. Existing regulations at 42 CFR 418.56 discuss the professional management of the hospice for services provided under arrangement.

Hospices must maintain evidence of the extraordinary events that required them to contract for the core services. They must assure that contracted staff is providing care that is consistent with the hospice philosophy and the patient's plan of care. Hospices may not routinely contract for a specific level of care or during specific hours of care. CMS is not mandating there be a written contract between hospices for this arrangement.

However, if the hospice feels it is necessary to maintain one for legal purposes, they may establish one.

Please don't confuse this waiver with the temporary measure effective October 1, 2002 – September 30, 2004 issued by CMS that allowed individual hospices to contract for nurses if the hospice could demonstrate a nursing shortage. This temporary measure from October 2002 was more of a long term fix and needed detailed documentation submitted to CMS. Please refer back to the November 2002 issue of Bureau Talk that addressed "The Impact of Nursing Shortage on Hospice Care". This new waiver is for a very short duration and agencies only need to notify our unit when implementing.

Contracting for Highly Specialized Services: A hospice program may contract for the services of a registered professional nurse if the services are highly specialized and are provided non-routinely and so infrequently that the provision of such services directly would be impracticable and prohibitively expensive. Highly specialized services are determined by the nature of the service and the nursing skill level required to be proficient in the service. Continuous care is not a specialized service, because while time intensive, it does not require highly specialized nursing skills.

CMS clarifies question regarding medical social worker requirements in hospice:

The social worker must meet the definition at 42 CFR 418.3. CMS does not have the authority to waive any of these requirements at this time. Therefore, the social worker must have a bachelor's degree from a school accredited by the Council on Social Work Education (CSWE).

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Physician Orders for Foley Catheter required for home health and hospice:

When receiving an order for a Foley catheter, make sure the sizes of the catheter and bulb are included. Failure to include the sizes of both will result in noncompliance.

Employee Disqualification List (EDL Checks)

All providers are encouraged to apply for user ID – access to the EDL website which will allow an agency to verify the EDL status of new applicants and current employees.

Each provider (agency) can have up to 3 users each with their own password. The person or user who will be accessing the database needs to be the one who completes the necessary paperwork. Each user will need to change their password monthly.

To obtain the forms necessary to apply for user ID, please call Greg Steinbeck at 573/522-2449, James Trowbridge at 573/522-2448 or Amber Parrish at 573/526-8544. Any one of these three can answer questions regarding this procedure.

Emergent Care

There continues to be questions about the timing and intent of this item. To ensure we use uniform definitions and the same terminology, refer to Chapter 8 in the Implementation Manual.

MO830: Emergent Care: Since the last time OASIS data was collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? Mark all that apply.

0 – No emergent care services (If no emergent care, go to MO855)
1 – Hospital emergency room (includes 23-hour holding)
2 – Doctor's office emergency visit/house call
3 – Outpatient department/clinic emergency (includes urgicenter sites)
UK – Unknown (If UK, go to MO855)

"Emergent care / unscheduled (within 24 hours) care", identifies whether the patient received an unscheduled visit to any (emergent) medical services other than home care agency services. Emergent care includes all unscheduled visits to such medical services. A "PRN" agency visit is NOT considered emergent care.

Response: If a patient went to the ER, was "held" at the hospital for observation, then released, the patient did receive emergent care. Exclude outpatient visits for scheduled diagnostic testing. Responses to this item include the entire period since the last time OASIS data was collected, including current events.

Assessment strategies: Ask the patient/caregiver if the patient has had any services for emergent care. Clarify that a doctor's office visit for an emergent problem, which is scheduled less than 24 hours in advance, is considered an emergent care visit.

Therefore, if a visit to the physician's office was scheduled less than 24 hours in advance, for whatever reason, it is considered an emergent care visit.

The clinician needs to use the information for any necessary care planning changes; for example, was there a change or addition in medications or treatments? The item does not justify "why" the patient went for emergent care, only that emergent care did occur or not. The "24 hour" time frame is a guideline to see if the need for the physician visit was emergent or not.

The collection and transmission of the Outcome and Assessment Information Set (OASIS) Data for private pay patients (non-Medicare/non-Medicaid) has been temporarily suspended.

Specifically, section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, temporarily suspended the requirement that Medicare-

approved HHAs collect OASIS data on non-Medicare/non-Medicaid patients.

Private pay patients (non-Medicare/non-Medicaid) are defined to include any patient for whom **(MO150)** the Current Payment Source for Home Care **does NOT include any of the following:**

1 – Medicare (Traditional fee-for-service)
2 – Medicare (HMO/managed care) –includes Medicare+Choice (M+C) and Medicare PPO
3 – Medicaid (Traditional fee-for services)
4 – Medicaid (HMO/managed care)

Therefore, if the answer on the MO150 current payment sources (who the agency is billing the services) is **1,2,3 or 4 - - you must still collect and transmit OASIS** and if a patient has **private pay insurance AND MO150 response is 1,2,3, or 4** to whom the agency is billing the services, the comprehensive assessment including **OASIS must be collected and transmitted**.

HHAs must continue to comply with the aspects of the regulation at 42 CFR 484.55 regarding the comprehensive assessment of patients.

- The agency must continue to provide a complete comprehensive assessment for all patients – (regardless of payment source), a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward the achievement of desired outcomes. The comprehensive assessment must also identify the patient's continuing need for home care, medical, nursing, rehabilitative, social and discharge planning needs.
- HHAs may continue to collect OASIS data on their non-Medicare/non-Medicaid patients for their own use.
- HHAs must continue to collect, encode, and transmit OASIS data for non-maternity Medicare and Medicaid patients that are age 18 and over and receiving skilled services.

The statute **does not suspend** any other aspects of the Comprehensive Assessment regulation. The time frames specified in 484.55 are NOT OASIS specific and therefore have NOT been suspended.

- HHAs must continue to complete an initial assessment either within 48 hours of referral or within 48 hours of the patient's return home, or on the physician-ordered start of care date.
- The comprehensive assessment must be completed no later than 5 days after the start of care,
- The comprehensive assessment must be updated as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status**, but not less frequently than –**
  1. The last five days of every 60 days beginning with the start of care date
  2. within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests
  3. and, at discharge

"Not less frequently than the last five days of every 60 days beginning with the start of care date" does NOT mean the HHA must wait until the 55^{th} – 60^{th} days to perform another comprehensive assessment on **non-Medicare/non-Medicaid patients**. The timetable for the subsequent 60-day period would then be measured from the completion date of the most recently completed assessment.

OR (another way of stating this) - clinicians may perform the comprehensive assessment for non-Medicare/non-Medicaid patients **MORE** frequently than the last 5 days of the 60-day episode without conducting another comprehensive assessment on day 55-60, and remain in compliance.

- Example: if a non-Medicare/non-Medicaid patient's payer source requires a revised plan of care on day 50 of the episode, the clinician could conduct the follow-up assessment earlier than day 50 without conducting a second assessment on day 55-60.